CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

DIVISION I—HCBS ILL AND HANDICAPPED WAIVER SERVICES

441—83.1(249A) Definitions.

"Blind individual" means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of ill and handicapped waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Disabled person" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Intermittent homemaker service" means homemaker service provided from one to three hours a day for not more than four days per week.

"Intermittent respite service" means respite service provided from one to three times a week.

"Medical institution" means a nursing facility or an intermediate care facility for the mentally retarded which has been approved as a Medicaid vendor.

"Substantial gainful activity" means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

441—83.2(249A) Eligibility. To be eligible for ill and handicapped waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) *Eligibility criteria.*

a. The person must be determined to be one of the following:

(1) Blind or disabled as determined by the receipt of social security disability benefits, or a disability determination made through the division of medical services. Disability determinations are made according to supplemental security income guidelines as per Title XVI of the Social Security Act.

(2) Aged 65 or over and residing in a county that is not served by the HCBS elderly waiver.

b. The person must be ineligible for medical assistance under other Medicaid programs or coverage groups with the exception of: the medically needy program, the in-home, health-related program when the person chooses the ill and handicapped waiver instead of the in-home, health-related program, the HCBS MR waiver when the person is a child under the age of 18 with mental retardation and meets the skilled nursing level of care, cases approved by the intradepartmental board for supplemental security income deeming determinations between 1982 and 1987, and children eligible for supplemental security income under Section 8010 of Public Law 101-239.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income and resources.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for the mentally retarded. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care.

Ill and handicapped waiver services will not be provided when the individual is an inpatient in a medical institution.

e. Rescinded IAB 12/6/95, effective 2/1/96.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at paragraphs 441—75.5(2)*"b"* and 441—75.5(4)*"c"* shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive a unit of adult day care, consumer-directed attendant care, counseling, home health aid, homemaker, nursing, or respite service per quarter.

83.2(2) *Need for services.*

a. The county social worker shall perform an assessment of the person's needs and determine the availability and appropriateness of services.

(1) This assessment shall be based, in part, on information in the completed Home- and Community-Based Services Assessment or Reassessment, Form SS-1644. Form SS-1644 is completed annually, or more frequently upon request or when there are changes in the client's condition.

(2) Case plans for persons aged 20 or under shall be developed or reviewed after the child's individual education plan and EPSDT plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) Those case plans for persons aged 20 or under which include homemaker or respite services beyond intermittent shall not be approved until a home health agency has made a request to cover the client's service needs through EPSDT and the plan is approved (signed and dated) by the human services area administrator.

b. The average monthly cost of all Medicaid expenditures, including ill and handicapped waiver services, shall not exceed the average monthly cost that would be incurred by Medicaid without the waiver based on the level of care that would have been provided the recipient in a nursing facility, skilled nursing facility, or intermediate care facility for the mentally retarded (ICF/MR). Individual service costs which make up the average monthly cost of ill and handicapped waiver services cannot exceed the established aggregate monthly cost limit for the level of care unless a waiver of this limit is granted by the division of medical services.

Aggregate monthly costs are limited as follows:

Skilled nursing facility	Nursing facility	ICF/MR
$2,480	$852	$3,019

A waiver of these limits shall be granted by the division of medical services if:

(1) A written request is made to the division of medical services to exceed the monthly cost limit. The request shall specify the amount, cost, and duration of the additional services, and provide a justification to show the services are cost-effective.

(2) The total cost of waiver services does not exceed the current maximum Medicaid payment allowed a facility for the level of care that would otherwise be provided to the recipient or the state's cost of skilled nursing care, whichever is higher.

(3) The waiver is found to be cost-effective.

441—83.3(249A) Application.

83.3(1) *Application for HCBS ill and handicapped waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS ill and handicapped waiver shall be subject to the number of clients to be served as set forth in the federally approved HCBS ill and handicapped waiver. The number of clients to be served are set forth at the time of each five-year renewal of the waiver or in amendments to the waiver. When the number of applicants exceeds the number of clients specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the division of medical services.

a. The county office shall contact the division of medical services for all applicants for the waiver to determine if a payment slot is available.

(1) For persons not currently receiving Medicaid, the county office shall contact the division of medical services by the end of the second working day after receipt of a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance.

(2) For current recipients, the county office shall contact the division of medical services by the end of the second working day after receipt of Form 470-0660, Home- and Community-Based Service Report, signed and dated by the recipient or a written request, signed and dated by the recipient.

b. By the end of the third day after the receipt of the completed Form PA-1107-0 or 470-0660, if no payment slot is available, persons shall be entered on a waiting list by the division of medical services according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, is signed or date-stamped in the county office, whichever is later. Clients currently eligible for Medicaid shall be added to the waiting list on the basis of the date Form 470-0660, or a written request, is signed and dated or date-stamped in the county office, whichever is later. In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their application rejected and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained.

83.3(3) *Approval of application.*

a. Applications for the HCBS ill and handicapped waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the completed assessment, Form SS-1644, has been submitted to the Iowa Foundation for Medical Care.

(5) The application is pending because the assessment, Form SS-1644, or the case plan has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, Form SS-1644, or case plan, the application shall be denied. The client shall have the right to appeal.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the client case plan are completed.

c. A client must be given the choice between HCBS ill and handicapped waiver services and institutional care. The income maintenance or service worker shall have the client or guardian complete and sign Form 470-0660, Home- and Community-Based Service Report, indicating the client's choice of home- and community-based services or institutional care.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations and the case plan are completed, but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the ill and handicapped waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs *"a"* and *"c"* of this subrule do not apply is the date on which the income eligibility and level of care determinations and the case plan are completed.

c. Eligibility for persons covered under subrule 83.2(1)"*c*"(3) shall exist on the date the income and resource eligibility and level of care determinations and case plan are completed, but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care. Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from ill and handicapped waiver services and reviewed for eligibility for other Medicaid coverage groups. The recipient will be notified of that decision through Form SS-1104-0, Notice of Decision. If the client returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of ill and handicapped waiver services or other Medicaid services, as applicable.

83.4(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker for ill and handicapped waiver services, Medicaid shall make no payments to ill and handicapped waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the ill and handicapped waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current case plan meeting the requirements listed in rule 441—83.7(249A).

441—83.6(249A) Allowable services. Services allowable under the ill and handicapped waiver are homemaker services, home health services, adult day care services, respite care services, nursing services, counseling services, and consumer-directed attendant care services as set forth in rule 441—78.34(249A).

441—83.7(249A) Case plan. A case plan shall be prepared for ill and handicapped waiver clients in accordance with rule 441—130.7(234) except that case plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition. In addition, the case plan shall include the frequency of the ill and handicapped waiver services and the types of providers who will deliver the services.

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the aggregate monthly costs established in 83.2(2)*"b,"* or are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the ill and handicapped waiver service for the person exceed the aggregate monthly costs established in 83.2(2)*"b."*

c. The client receives care in a hospital, nursing facility, or intermediate care facility for the mentally retarded for 30 days in any one stay for purposes other than respite care.

d. The client receives ill and handicapped waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.8(3) Reduction of services shall apply as in subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to **83.20** Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

"Interdisciplinary team" means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client's need for services.

"Iowa Foundation for Medical Care" means the entity designated by the federal government to be the peer review organization for the state of Iowa.

"Long-term care coordinating unit designated case management project for frail elderly" means the case management system which conducts interdisciplinary team meetings to develop and update care plans for persons aged 65 and older.

"Medical institution" means a nursing facility which has been approved as a Medicaid vendor.

"Project coordinator" means the person designated by the administrative entity to oversee the long-term care coordinating unit's designated case management project for the frail elderly.

"Third-party payments" means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) *Eligibility criteria.* All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.

b. A resident of one of the following counties:

Adair	Davis	Jefferson	Plymouth
Adams	Decatur	Johnson	Pocahontas
Allamakee	Delaware	Jones	Polk
Appanoose	Des Moines	Keokuk	Pottawattamie
Benton	Dickinson	Kossuth	Poweshiek
Black Hawk	Dubuque	Lee	Ringgold
Boone	Emmet	Linn	Sac
Bremer	Fayette	Louisa	Scott
Buchanan	Floyd	Lucas	Story
Buena Vista	Franklin	Lyon	Tama
Butler	Fremont	Madison	Union
Calhoun	Greene	Mahaska	Van Buren
Carroll	Grundy	Marion	Wapello
Cass	Guthrie	Marshall	Warren
Cedar	Hamilton	Mills	Washington
Cerro Gordo	Hancock	Mitchell	Wayne
Cherokee	Hardin	Monona	Webster
Chickasaw	Harrison	Monroe	Winnebago
Clarke	Howard	Montgomery	Winneshiek
Clay	Humboldt	Muscatine	Woodbury
Clayton	Ida	O'Brien	Worth
Clinton	Iowa	Osceola	Wright
Crawford	Jackson	Page	
Dallas	Jasper	Palo Alto	

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)*"b"* and 75.5(4)*"c"* shall be applied.

d. Certified as being in need of the intermediate or skilled level of care. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care.

Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

e. Determined to need services as described in subrule 83.22(2).

f. Under the case management of a member of the long-term care coordinating unit designated case management project for the frail elderly.

83.22(2) *Need for services.*

a. Applicants for elderly waiver services shall have an assessment of the need for service and the availability and appropriateness of service. The tool used to complete the assessment shall be the assessment tool designated by the long-term care coordinating unit established at Iowa Code section 231.58. The assessment shall be completed by the designated case management project for the frail elderly in the community or the local service worker. The Iowa Foundation for Medical Care shall be responsible for determining the level of care based on the completed assessment tool and supporting documentation as needed.

b. The average monthly cost of all Medicaid expenditures, including elderly waiver services exclusive of home and vehicle modification, shall not exceed the average monthly cost that would be incurred by Medicaid without the waiver based on the level of care that would have been provided the recipient in a nursing facility or skilled nursing facility. Individual service costs which make up the average monthly cost of elderly waiver services cannot exceed the established aggregate monthly cost limit for the level of care unless a waiver of this limit is granted by the division of medical services.

Aggregate monthly costs are limited as follows:

Skilled level of care	Nursing level of care
$2,480	$852

A waiver of these limits shall be granted by the division of medical services if:

(1) A written request is made to the division of medical services to exceed the monthly cost limit. The request shall specify the amount, cost, and duration of the additional services, and provide a justification to show the services are cost-effective.

(2) The total cost of waiver services does not exceed the current maximum Medicaid payment allowed a facility for the level of care that would otherwise be provided to the recipient or the state's cost of skilled nursing care, whichever is higher.

(3) The waiver is found to be cost-effective.

83.22(3) *Providers—standards.* Participants in the waiver shall be case managed by providers who meet all the following standards:

a. Be a member of the long-term care coordinating unit designated case management project for the frail elderly.

b. Have a bachelor's degree in a human services field or be currently licensed as a registered nurse. Up to two years, relevant experience may be substituted for two years of the educational requirement.

c. Have formal training in completion of the assessment tool.

d. Receive formal case management training as specified by the long-term care coordinating unit.

441—83.23(249A) Application.

83.23(1) *Application for HCBS elderly waiver.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) *Approval of application.*

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The client or guardian shall sign Form 470-3156, Long-Term Care Coordinating Unit Common Care Plan, indicating the client's choice of caregiver.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) *Effective date of eligibility.*

a. The effective date of eligibility cannot precede the date the department service worker signs the case plan. Applicants without a case plan signed by the department service worker are not eligible for the waiver.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The recipient will be notified of that decision through Form SS-1104-0, Notice of Decision. If the client returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, and consumer-directed attendant care services as set forth in rule 441—78.37(249A).

441—83.27(249A) Case plan. Form 470-3156, Long-Term Coordinating Unit Common Care Plan, shall be completed jointly by the area agency on aging case management program for the frail elderly and department service worker.

441—83.28(249A) Adverse service actions.

83.28(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the elderly waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.22(2)*"b,"* or are not met by services provided.

d. Needed services are not available or received from qualifying providers.

e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days in any one stay for purposes other than respite care.

d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person's primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to **83.40** Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of "Morbidity and Mortality Weekly Report."

"Client participation" means the amount of the recipient's income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

"Iowa Foundation for Medical Care" means the entity designated by the federal government to be the peer review organization for the state of Iowa.

"Medical institution" means a nursing facility or hospital which has been approved as a Medicaid vendor.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care. AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, ADC, or ADC-related coverage groups; medically needy at hospital level of care; eligible under a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

83.42(2) *Need for services.*

a. The county social worker shall perform an assessment of the person's need for waiver services and determine the availability and appropriateness of services. This assessment shall be based, in part, on information in the completed Home- and Community-Based Services Assessment or Reassessment, Form SS-1644. Form SS-1644 shall be completed annually.

b. The average monthly cost of all Medicaid expenditures, including AIDS/HIV waiver services, shall not exceed the average monthly cost that would be incurred by Medicaid without the waiver based on the level of care that would have been provided the recipient in a nursing facility, skilled nursing facility, or hospital. Individual service costs which make up the average monthly cost of AIDS/HIV waiver services cannot exceed the established limit of $1650 unless a waiver of this limit is granted by the division of medical services.

A waiver of this limit shall be granted by the division of medical services if:

(1) A written request is made to the division of medical services to exceed the established monthly cost limit. The request shall specify the amount, cost, and duration of the additional services, and provide a justification to show the services are cost-effective.

(2) The total cost of waiver services does not exceed the current maximum Medicaid payment allowed a facility for the level of care that would otherwise be provided to the recipient or the state's cost of skilled nursing care, whichever is higher.

(3) The waiver is found to be cost-effective.

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made or pended although the completed assessment, Form SS-1644, has been submitted to the Iowa Foundation for Medical Care.

(3) The application is pending because the assessment, Form SS-1644, or the case plan has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, Form SS-1644, or case plan, the application shall be denied. The client shall have the right to appeal.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the client case plan are completed.

c. A client must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The income maintenance or service worker shall have the client or guardian complete and sign Form 470-0660, Home- and Community-Based Service Report, indicating the client's choice of home- and community-based services or institutional care.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations and the case plan are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations and the case plan are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form SS-1104-0, Notice of Decision. If the client returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied, is the date on which the income eligibility and level of care determinations and the case plan are completed, but shall not be earlier than the first of the month following the date of application.

83.43(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling services, home health aide services, homemaker services, nursing care services, respite care services, home-delivered meals, and consumer-directed attendant care services as set forth in rule 441—78.38(249A).

441—83.47(249A) Case plan. A case plan shall be prepared for AIDS/HIV waiver clients in accordance with rule 441—130.7(234) except that case plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition. In addition, the case plan shall include the frequency of the AIDS/HIV waiver services and the types or providers who will deliver the services.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.42(2)*"b"* or cannot be met by the services provided under the waiver.

d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. If dissatisfied with that decision, an appeal may be filed with the department.

441—83.50(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code section 249A.4.

441—83.51 to **83.59** Reserved.

DIVISION IV—HCBS MR WAIVER SERVICES

441—83.60(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

"Adult" means a person with mental retardation aged 18 or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with mental retardation aged 17 or under.

"Client participation" means the posteligibility amount of the consumer's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Individual comprehensive plan (ICP)" (also known as individual program plan) means a written consumer-centered outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It involves more than one agency.

"Individual treatment plan (ITP)" (also known as an individual service plan, individual education plan, and individual habilitation plan) means a written goal-oriented plan of services developed for a consumer by the consumer and the provider agency.

"Intermediate care facility for the mentally retarded (ICF/MR)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons who are mentally retarded and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each individual function at the greatest ability and is an approved Medicaid vendor.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Mental retardation" means a diagnosis of mental retardation under this division which shall be made only when the onset of the person's condition was prior to the age of 18 years and shall be based on an assessment of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. A diagnosis of mental retardation shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified mental retardation professional" means a person who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master's degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.
10. A human services professional who must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

441—83.61(249A) Eligibility. To be eligible for HCBS MR waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Be determined through the department to have a primary disability of mental retardation.

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/MR. The Iowa Foundation for Medical Care shall be responsible for annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

(1) Persons shall have their names placed on the HCBS MR waiver referral list with the division of medical services, or

(2) Currently reside in a residential care facility for the mentally retarded or foster care group home for the mentally retarded, or

(3) Currently reside in an ICF/MR or nursing facility.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, an adult must receive one unit of either consumer-directed attendant care, supported community living, respite, or supported employment service per month. Children shall, at a minimum, receive one unit of either consumer-directed attendant care, respite service or supported community living service per month under this program.

f. Have an individual comprehensive plan completed annually.

g. For supported employment services:

(1) Be at least age 18.

(2) Rescinded IAB 7/1/98, effective 7/1/98.

(3) Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.

(4) Not reside in a medical institution.

h. Have an individual comprehensive plan or service plan approved by the department.

83.61(2) *Need for services.*

a. Consumers currently receiving Medicaid case management or services of a department-qualified mental retardation professional (QMRP) shall have the applicable coordinating staff and other interdisciplinary team members complete the Functional Assessment Tool, Form 470-3073, and identify the consumer's needs and desires as well as the availability and appropriateness of the services.

b. Consumers not receiving services as set forth in paragraph *"a"* who are applying for the HCBS MR waiver service shall have a department service worker or a case manager paid by the county without Medicaid funds complete the Functional Assessment Tool, Form 470-3073, for the initial level of care determination; establish an initial interdisciplinary team for HCBS MR services; and, with the initial interdisciplinary team, identify the consumer's needs and desires as well as the availability and appropriateness of services.

c. Persons meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service except as follows:

(1) Requests to exceed unit maximums shall be granted only for the respite service unit maximum.

(2) Requests to exceed respite unit maximums require special review by the administrator of the division of medical services' designee for children and state cases, or the county board of supervisors' designee for adults and, based on a written determination, may be reduced or denied as not cost-effective.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The service worker, department QMRP, or Medicaid case manager shall complete the Functional Assessment Tool, Form 470-3073, for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary for completion of Form 470-3073 or other circumstances beyond the worker's control.

g. At initial enrollment the service worker, department QMRP, case manager paid by the county without Medicaid funds, or Medicaid case manager shall establish an HCBS MR interdisciplinary team for each consumer and, with the team, identify the consumer's need for service based on the consumer's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing assessments:

(1) The assessment shall be based, in part, on information on the completed Functional Assessment Tool, Form 470-3073.

(2) Service plans or individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the individual education plan (IEP) and early periodic screening, diagnosis and treatment (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) Service plans or ICPs for consumers aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through EPSDT and receives a determination of whether EPSDT is appropriate.

(4) Service plans or ICPs for consumers aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the division of medical services, designee or the county board of supervisors' designee. The service worker, department QMRP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the division of medical services' designee or the county board of supervisors' designee to make a decision regarding the need for supported community living beyond intermittent.

83.61(3) *HCBS MR program limit.* The number of persons served shall be subject to a limit based on the number of payment slots set forth in the HCBS MR waiver amendment. The department shall make a request to the Health Care Financing Administration (HCFA) to adjust the program limit annually to be effective each July 1 based upon the county management plans submitted by the state and counties. The department shall also submit a request to HCFA for changes to the program limit to be effective January 1 if requested by a county during the month of September.

a. The payment slots are on a county basis for adults with legal settlement in a county and are on a statewide basis for children and adults without a county of legal settlement.

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list shall be sent to the person by the department.

83.61(4) *Securing a payment slot.*

a. The county department office shall contact the division of medical services for state cases and children or the central point of coordination administrator for the county of legal settlement for adults to determine if a payment slot is available for all new applications for the HCBS MR program.

(1) For persons not currently receiving Medicaid, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, or after disability determination, whichever is later.

(2) For current Medicaid recipients, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a signed and dated Form SS-1645-0, Home- and Community-Based Service Report.

(3) A payment slot is assigned to the applicant upon confirmation of an available slot.

(4) Once assigned, the payment slot shall be held for the applicant for 180 days to arrange services unless the person has been determined ineligible for the program. If the slot has not been used in 180 days, it reverts to the county for use by the next applicant on the waiting list, if applicable. The applicant must reapply for a new slot.

b. On the third day after the receipt of the completed Form PA-1107-0 or SS-1645-0, if no payment slot is available, persons shall be entered on a waiting list by the division of medical services or county according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, is date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date the consumer requests HCBS MR program services as documented by the date of the consumer's signature on Form SS-1645-0. In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their application rejected, but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list. The county central point of coordination administrator for adults and the division of medical services for children and state cases shall contact the county department when a slot becomes available. The county department shall contact the applicant regarding the availability of a slot.

441—83.62(249A) Application.

83.62(1) *Application for HCBS MR waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS MR waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/MR care. The case manager or worker shall have the consumer or legal representative complete and sign Part E of Form SS-1645, Home and Community Based Service Report, indicating the consumer's choice of care.

d. HCBS MR waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS MR waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

83.62(4) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form SS-1104-0, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual ICP staffing meeting and the corresponding long-term care need determination.

83.62(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of eligibility for HCBS MR waiver services shall be completed at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS MR waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modifications, supported employment, and consumer-directed attendant care services as set forth in rule 441—78.41(249A).

441—83.67(249A) Individual comprehensive plan or service plan. An individual comprehensive plan (ICP) or service plan shall be prepared and utilized for each HCBS MR waiver consumer. The ICP or service plan shall be developed by the interdisciplinary team which includes the consumer and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved. The ICP shall be stored by the case manager for a minimum of three years. The ICP staffing shall be conducted before the current ICP expires. The service plan or ICP shall incorporate the concept of managed care. The plan shall be in accordance with rule 441—24.44(225C) and shall additionally include the following information to assist in evaluating the program:

83.67(1) A listing of all services received by a consumer at the time of waiver program enrollment.

83.67(2) For supported community living consumers the plan shall include identification of:

a. The consumers' living environment at the time of waiver enrollment.

b. The number of hours per day of on-site staff supervision needed by the consumer.

c. The number of other waiver consumers who will live with the consumer in the living unit.

83.67(3) Rescinded IAB 1/4/95, effective 3/1/95.

83.67(4) An identification and justification of any restriction of a consumer's rights including, but not limited to:

a. Maintenance of personal funds.

b. Self-administration of medications.

83.67(5) The name of the service provider responsible for providing the service.

83.67(6) The service funding source.

83.67(7) The amount of the service to be received by the consumer.

83.67(8) Documentation. The Medicaid case manager shall ensure that the consumer's case file contains the consumer's ICP or service plan, the county or department's final approval of services and service costs and the following completed forms:

a. Eligibility for Medicaid Waiver, Form RS-1238.

b. Home- and Community-Based Service Report, Form SS-1645-0.

c. Medicaid Home- and Community-Based Payment Agreement, Form MA-2171.

83.67(9) Approval of plan. The administrator of the division of medical services' designee for children and state cases, or the county board of supervisors' designee for adults, shall review the availability and appropriateness of services as specified in the individual comprehensive plan or service plan and may, based on a written determination, request the individual comprehensive plan or service plan be modified so that the services are cost-effective.

a. A summary of the services and service costs specified in the proposed service plan or ICP must be received and date-stamped by the HCBS MR unit in the department or the county central point of coordination ten working days prior to the planned implementation date.

b. The department or county has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan or ICP unless the parties mutually agree to extend that time frame.

c. If the department or county and service worker or case manager are unable to agree on the terms of the services or service cost within ten days, the department or county has final authority regarding the services and service cost.

d. If a notice of decision is not received from a county within 30 days from the date of request for services, the request shall be sent to the department of human services with documentation verifying the original submission of the request to the county. A letter from the department of human services shall be sent to the county central point of coordination and county board of supervisors requesting a response within ten days. If no response is received within ten days, the division of medical services designee will make the decision as stated in paragraph *"b."*

441—83.68(249A) Adverse service actions.

83.68(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The applicant is not eligible for the services.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The HCBS MR service is not identified in the applicant's individual comprehensive plan (ICP).

f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.

g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.68(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The HCBS MR service is not identified in the consumer's annual ICP.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.

g. The consumer receives services from other Medicaid waiver programs.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or consumer is entitled to have a review of the level of care determination by the Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. If dissatisfied with that decision, the applicant or consumer may file an appeal with the department.

The applicant or consumer for whom the county has legal payment responsibility shall be entitled to a review of adverse decisions by the county by appealing to the county pursuant to 441—25.21(331). If dissatisfied with the county's decision, the applicant or consumer may file an appeal with the department pursuant to rule 441—83.69(249A).

441—83.70(249A) County reimbursement. The county board of supervisors of the consumer's county of legal settlement shall reimburse the department for all the nonfederal share of the HCBS MR waiver service expenses to adults. The county shall enter into a Medicaid Home- and Community-Based Payment Agreement, Form MA-2171, with the department for reimbursement of the nonfederal share of the cost of service provided to HCBS MR waiver adults.

83.70(1) *County agreement.* The county shall enter into the agreement using the criteria in subrules 83.61(2) and 83.62(1).

83.70(2) *Continuation of services for HCBS MR consumers.* The county shall continue to provide HCBS MR services to consumers with mental retardation who are enrolled in the HCBS MR program on August 1, 1996. The county shall continue to provide HCBS MR services to children who are enrolled in the HCBS MR program after the children turn 18. The state slot for a child in the HCBS MR program will transfer to the county of legal settlement when the child turns 18.

83.70(3) *Continuation of services for HCBS ill and handicapped consumers.* The county shall maintain continuity of services to consumers with mental retardation who are enrolled at the ICF/MR level of care in the HCBS ill and handicapped program at the age of 18.

441—83.71(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

441—83.72(249A) Rent subsidy program. Recipients of the HCBS MR waiver program may be eligible for a rent subsidy program. See 441—Chapter 53.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to **83.80** Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

"Adaptive" means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a brain injury aged 18 years or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Brain injury" means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.
Malignant neoplasms of brain, frontal lobe.
Malignant neoplasms of brain, temporal lobe.
Malignant neoplasms of brain, parietal lobe.
Malignant neoplasms of brain, occipital lobe.
Malignant neoplasms of brain, ventricles.
Malignant neoplasms of brain, cerebellum.
Malignant neoplasms of brain, brain stem.
Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
Malignant neoplasms of brain, cerebral meninges.
Malignant neoplasms of brain, cranial nerves.
Secondary malignant neoplasm of brain.
Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
Benign neoplasm of brain and other parts of the nervous system, brain.
Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
Encephalitis, myelitis and encephalomyelitis.
Intracranial and intraspinal abscess.
Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage.
Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.
Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.

Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with a brain injury aged 17 years or under.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Individual comprehensive plan (ICP)" (also known as individual program plan) means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It involves more than one provider.

"Individual treatment plan (ITP)" (also known as an individual service plan, individual education plan, and individual habilitation plan) means a written, goal-oriented plan of services developed for a consumer by the consumer and the provider.

"Intermittent supported community living service" means supported community living service provided from one to three hours a day for not more than four days a week.

"Iowa Foundation for Medical Care" is the entity designated by the federal government to be the peer review organization for the state of Iowa.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for the mentally retarded, or hospital which has been approved as a Medicaid vendor.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Service coordination" means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of brain injury.

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution; or be eligible for medically needy.

c. Be aged 1 month to 64 years.

d. Be a U.S. citizen and Iowa resident.

e. Be currently a resident of a medical institution and have been for at least 30 consecutive days at the time of initial application for the brain injury waiver.

f. Be determined by the Iowa Foundation for Medical Care as in need of intermediate care facility for the mentally retarded (ICF/MR), skilled nursing, or ICF level of care.

g. Be assessed by the Iowa Foundation for Medical Care as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.

h. At a minimum, receive case management services each quarter, and use at least one unit of respite or supported community living services each quarter under this program.

i. Choose HCBS.

83.82(2) *Need for services.*

a. The consumer shall have an individual comprehensive plan approved by the department which is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed prior to services provision and annually thereafter.

The case manager shall establish the interdisciplinary team for the consumer, and with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the Iowa Foundation for Medical Care.

(2) Individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the child's individual education plan (IEP) and early periodic screening, diagnosis and treatment (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) ICPs for consumers aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through EPSDT and receives a determination of whether EPSDT is appropriate.

(4) ICPs for consumers aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the division of medical services designee. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the ICP. The rationale must contain sufficient information for the division of medical services designee, or for an ICF/MR level of care consumer, the designee of the county of legal settlements board of supervisors, to make a decision regarding the need for supported community living beyond intermittent.

b. Rescinded IAB 7/1/98, effective 7/1/98.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

d. The total monthly cost of brain injury waiver services shall not exceed $2,650 per month.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Access to HCBS BI waiver services for adult persons meeting the ICF/MR level of care shall be limited to persons who are residing in an ICF/MR and who have resided there for at least 30 days immediately preceding waiver application. In addition, waiver slots for these persons shall be identified in the county management plan submitted to the department pursuant to 441—Chapter 25. Each county shall inform the department regarding the number of payment slots desired by April 1 and October 1 of each year. A county may choose to establish no payment slots under the HCBS BI waiver.

a. The payment slots shall be on a county basis for adults with legal settlement in a county and on a statewide basis for children and adults without a county of legal settlement.

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

83.82(4) *Securing a payment slot.*

a. The county department office shall contact the division of medical services for state cases and children or the county of legal settlement for adults to determine if a payment slot is available for all new applications for the HCBS BI waiver program which require the ICF/MR level of care.

(1) For persons not currently receiving Medicaid, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance.

(2) For current Medicaid recipients, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a signed and dated Form SS-1645-0, Home- and Community-Based Service Report.

b. On the third day after the receipt of the completed Form PA-1107-0 or SS-1645-0, if no payment slot is available, persons shall be entered on a waiting list by the division of medical services or county according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, is date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date the consumer requests HCBS BI program services as documented by the date of the consumer's signature on Form SS-1645-0. In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

The county shall have financial responsibility for the state share of the costs of services for these consumers as stated in rule 83.90(249A). The county shall include these ICF/MR level of care brain-injured consumers in their annual county management plan which is approved by the state.

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application. The discharge planner shall provide to the Iowa Foundation for Medical Care (IFMC) review coordinator all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IFMC review coordinator shall inform the discharge planner on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. A consumer shall be given the choice between waiver services and institutional care. The consumer or legal representative shall complete and sign Form 470-0660, Home- and Community-Based Service Report, indicating the consumer's choice of caregiver. This shall be arranged by the medical facility discharge planner.

d. The medical facility discharge planner shall contact the appropriate case manager for the consumer's county of residence to initiate development of the consumer's ICP and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by IFMC to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form SS-1104-0, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment services, adult day care, and consumer-directed attendant care services, as set forth in rule 441—78.43(249A).

441—83.87(249A) Individual comprehensive plan. An individualized comprehensive plan (ICP) shall be prepared and utilized for each HCBS BI waiver consumer. The ICP shall be developed by an interdisciplinary team which includes the consumer and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The ICP shall be stored by the case manager for a minimum of three years. The ICP staffing shall be conducted before the current ICP expires.

83.87(1) *Information in plan.* The plan shall be in accordance with rule 441—24.44(225C) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. For supported community living consumers the plan shall include identification of:

(1) The consumers' living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

(3) The number of other waiver consumers who will live with the consumer in the living unit.

c. An identification and justification of any restriction of a consumer's rights including, but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The names of all providers responsible for providing all services.

e. All service funding sources.

f. The amount of the service to be received by the consumer.

83.87(2) *Case plans for consumers aged 20 or under.* Case plans or individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the child's individual education plan (IEP) and early periodic screening, diagnosis and treatment plans (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those programs.

Case plans or ICPs for consumers aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the division of medical services designee, or when a county voluntarily chooses to participate, by the county board of supervisors, designee or the division of medical services designee. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) *Annual assessment.* The Iowa Foundation for Medical Care shall assess the consumer annually and certify the consumer's need for long-term care services. The Iowa Foundation for Medical Care shall be responsible for determining the level of care based on the completed Brain Injury Waiver Functional Assessment, Form 470-3283, and supporting documentation as needed.

83.87(4) *Case file.* The Medicaid case manager must ensure that the consumer case file contains the consumer's ICP, the department's, or if the county is voluntarily participating, the county's final approval of service costs and the following completed forms:

a. Eligibility for Medicaid Waiver, Form RS-1238.

b. Home and Community Based Service Report, Form SS-1645.

c. Medicaid Home and Community Based Payment Agreement, Form MA-2171.

441—83.88(249A) Adverse service actions.

83.88(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The brain injury waiver service is not identified in the consumer's individual comprehensive plan (ICP).

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.88(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The brain injury service is not identified in the consumer's annual ICP.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or consumer is entitled to have a review of the level of care determination by the Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. If dissatisfied with that decision, the consumer may file an appeal with the department.

The applicant or consumer for whom the county has legal payment responsibility shall be entitled to a review of adverse decisions by the county by appealing to the county pursuant to rule 441—25.21(331). If dissatisfied with the county's decision, the applicant or consumer may file an appeal with the department.

441—83.90(249A) County reimbursement. The county board of supervisors of the consumer's county of legal settlement shall reimburse the department for all the nonfederal share of the cost of brain injury waiver services to persons at the ICF/MR level of care with legal settlement in the county who are coming onto the waiver from a minimum 30-day residence in an ICF/MR facility for which the county has been financially responsible. The county shall enter into a Medicaid Home and Community Based Payment Agreement, Form MA-2171, with the department for reimbursement of the nonfederal share of the cost of services provided to HCBS brain injury waiver adults at the ICF/MR level of care who meet the criteria stated above.

The county shall enter into the agreement using the criteria in subrule 83.82(2).

441—83.91(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the consumer may be required to provide additional information. To obtain this information, a consumer may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

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